Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005100	A. BUILDING: ______ B. WING ______	12/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL OF ANDERSON AND MADISC	**1515 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one State hospital complaint. Complaint Number: IN00138953 Unsubstantiated: Lack of Sufficient Evidence Date: 12/26/13 Facility Number: 005100 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Community Hospital of Anderson and Madison County is in compliance with 410 IAC 15-1.5-6, Nursing Services; 410 IAC 15-5-5, Medical Staff; 410 IAC 15-1.5-8, Physical Plant Maintenance, and Environmental Services; and 410 IAC 15-1.5-10, Utilization Review and Discharge Planning Services, Indiana Hospital Licensure Rules. QA: claughlin 02/03/14	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE